TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Russell Juno, M.D.

Respondent Name
Texas Association of Counties RMP

MFDR Tracking Number
M4-16-0153-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
September 18, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… this request was in response to a $40.96 reduction of the $840.00 for the FCE performed on 12-1-15."

Amount in Dispute: $40.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After careful review the third party administrator (TPA), York Risk Services Group, has determined that reimbursement has been made in accordance with Rule §134.204g."

Response Submitted by: York Risk Services Group

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 1, 2014	Functional Capacity Evaluation	$40.96	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the requirements for submitting medical bills.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for Division-specific services.
4. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 309 – The charge for this procedure exceeds the fee schedule allowance.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 29 – The time limit for filing has expired.

- 18 – Exact duplicate claim/service.

Issues

1. Did the requestor timely file the disputed charges in accordance with Texas Administrative Code §133.20?
2. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied additional payment for disputed services on the reconsideration Explanation of Review with claim adjustment reason code 29 – "THE TIME LIMIT FOR FILING HAS EXPIRED." 28 Texas Administrative Code §133.20 (b) states, in relevant part, "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided…"

   The services is in dispute are sixteen units of a Functional Capacity Evaluation on date of service December 1, 2014. Review of the submitted information finds that the insurance carrier received the initial bill for the disputed services on December 4, 2014. This is within 95 days from the date of service. The Division finds that the requestor timely filed the disputed charges in accordance with Texas Administrative Code §133.20. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. The MAR for the disputed services may be found by dividing the Division conversion factor for the date of service by the Medicare conversion factor and multiplying by the total Medicare fee. The Division conversion factor for 2014 is $55.75. The Medicare conversion factor for the disputed date of service is $35.8228. The total Medicare fee for the date of service in the location the services were provided is $32.09. The MAR is calculated as follows:

   ($55.75 / $35.8228) x $32.09 = $49.94 x 16 units = $799.04

3. The total MAR for the disputed services is $799.04. The insurance carrier paid $799.04. No further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	October 23, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.